

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/19/2015
NAME OF PROVIDER OR SUPPLIER SCHNECK MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 411 W TIPTON ST SEYMOUR, IN 47274		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This survey was for the investigation of one State complaint.</p> <p>Complaint number: #IN00166873</p> <p>Substantiated; no deficiencies related to the allegations are cited.</p> <p>Date of survey: 8/19/2015</p> <p>Facility #: 005060</p> <p>Schneck Medical Center is in compliance with 410 IAC 15-1.5-5, Medical Staff Services, Hospital Licensure Rules.</p> <p>QA: cjl 09/09/15</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE